

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4691

1. PLACE OF DEATH a. COUNTY Howard		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Woodbine		c. LENGTH OF STAY IN 1b 27 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Woodbine		d. STREET ADDRESS R. D.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ALBERT		First R.	Middle BARTH	Lost	4. DATE OF DEATH April	Month 17,	Day 1960
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH May 12, 1879	9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (Retired)		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Barth		14. MOTHER'S MAIDEN NAME Mary Wolbert					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-36-7035		17. INFORMANT Mrs. Cornelia I. Barth, Same		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X		DUE TO <i>Cerebral hemorrhage, cerebral</i>				INTERVAL BETWEEN ONSET AND DEATH 1956	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. failure, Arterosclerosis generalized		DUE TO <i>Chronic brain syndrome</i>				to 17 April 60	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 1956 to 17 April 1960 , that (I) (we) last saw the deceased alive on 17 April 1960 , and that death occurred at 2:45 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Howard E. Hall		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED 18 April 60	
22c. PHYSICIAN'S NAME (Type) Howard E. Hall M.D.		22d. ADDRESS Sykesville, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4-20-1960	23c. NAME OF CEMETERY OR CREMATORIUM Morgan Chapel Cemetery		23d. LOCATION (City, town, or county) Carroll Co., Maryland		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz, Winfield, Maryland		ADDRESS		25a. REC'D BY REGISTRAR DATE APR 21 '60		25b. REGISTRAR'S SIGNATURE Chiba S. Kraus	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4640 1:4602

1. PLACE OF DEATH a. COUNTY <i>Harvard</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Jessup</i>		c. LENGTH OF STAY IN 1b <i>8 years</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Blvd</i>		e. STREET ADDRESS <i>Wash. Blvd</i>	
3. NAME OF DECEASED (Type or print) <i>Alice</i>		4. DATE OF DEATH Month Day Year <i>April 15 1960</i>	
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <i>Feb 12, 1881</i>	
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>	
9. AGE (In years last birthday) <i>79 yrs.</i>		10. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John Hammond Brown</i>		14. MOTHER'S MAIDEN NAME <i>Georgia Shipley</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Mrs Elizabeth Oberley, Jessup, Md</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY (IMMEDIATE CAUSE (a)) <i>420.1 Coronary Occlusion</i>	
DUE TO { Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>—</i>		DUE TO (b) <i>Hypertensive Cardiovascular Disease</i>	
DUE TO (c) <i>—</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. 19 p. m. <i>—</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <i>Baltimore, Md</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>4/1/59</i> to <i>4/15/60</i> , that (I) (we) last saw the deceased alive on <i>4/5/60</i> , and that death occurred at <i>5 A.M.</i> from the causes and on the date stated above.		22b. DATE SIGNED	
22a. SIGNATURE <i>Frank E. Shipley</i>		22b. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <i>Frank E. Shipley</i>		22d. ADDRESS <i>Bavage, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial April 18, 1960</i>		23b. DATE THEREOF <i>April 18, 1960</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Laudan Park Cem</i>		23d. LOCATION (City, town, or county) (State) <i>Baltimore, Md</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>De Witt Donaldson, Laurel, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>APR 19 '60</i>	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>			

420.1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

64603

Reg. Dist. No.

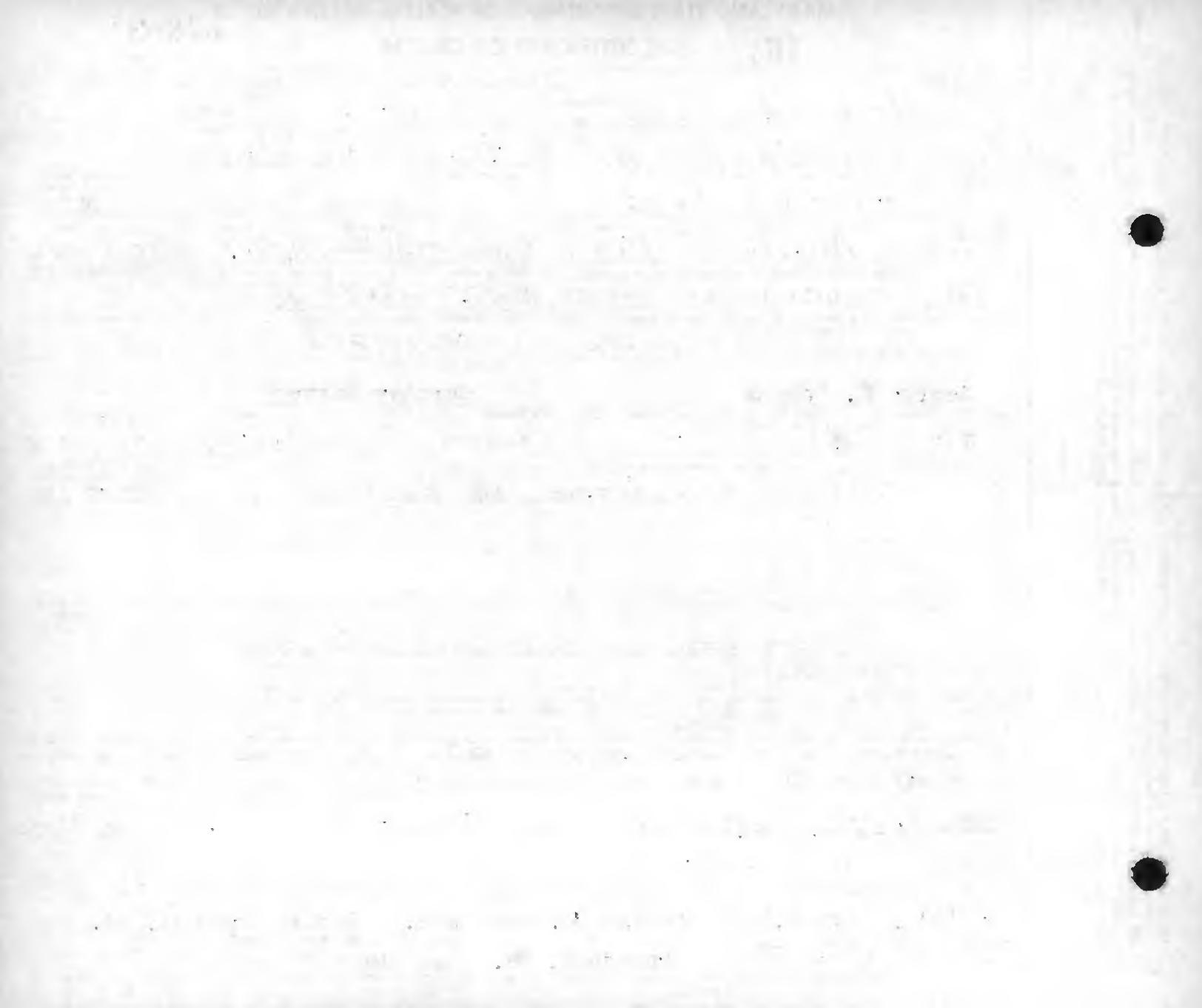
4641

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Howard		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Woodbine		c. LENGTH OF STAY IN 1b 5 yrs		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Florence Road.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Woodbine		
3. NAME OF DECEASED (Type or print) Annie		First May	Middle Burdette	
4. DATE OF DEATH April 30, 1960	Month Day Year	5. SEX Female		
6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 22, 1869	9. AGE (in years last birthday) 90	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George W. Bowman		14. MOTHER'S MAIDEN NAME Carolyn Harvey		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] No	16. SOCIAL SECURITY NO. —	INFORMANT Courtney Burdette (son)	Address woodbine Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		INTERVAL BETWEEN ONSET AND DEATH About 1 yr.		
DUE TO (c)				
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 1, 1953 to April 1, 1960 , that I last saw the deceased alive on April 30, 1960 , and that death occurred at 8 P.M. from the causes and on the date stated above.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
ACTUAL SIGNATURE W.B. Culwell		M.D. W.B. Culwell		ADDRESS (Street, city or town, state) Mount Airy, Md.
PHYSICIAN'S NAME (Type)				DATE SIGNED 4/30/60
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 4, 1960	22c. NAME OF CEMETERY OR CREMATORIUM Poplar Springs Meth.	22d. LOCATION (City, town, or county) (State) Poplar Springs, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Olin L. Mohamth		ADDRESS Damascus, Md.	24a. REC'D BY REGISTRAR DATE MAY 3 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

64604

Reg. Dist. No.

4632

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Howard		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Maryland		b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		d. STREET ADDRESS Boone Lane			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Boone Lane				d. STREET ADDRESS Boone Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) LOTTIE MATILDA COOLING		First	Middle	Last	4. DATE OF DEATH April 3 1960	Month	Day	Year 19	
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH March 4, 1887	9. AGE (In years lost birthday) 73 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Frederick Co. Md		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Sam Andrews				14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT Louis Cook, Ellicott City, Md		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c) <i>Pulmonary edema</i>									
INTERVAL BETWEEN ONSET AND DEATH 30 min									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Ellicott City		(County) Baltimore	(State) Md
20c. TIME OF INJURY Hour a. m. p. m.		19							
21. I certify that I attended the deceased from May 28, 1960 to April 3, 1960 , that I last saw the deceased alive on April 3, 1960 , and that death occurred at 11 A.M. from the causes and on the date stated above.									
ACTUAL SIGNATURE Thomas F. Herbert, M.D.									
ADDRESS (Street, city or town, state) Ellicott City, Md.									
DATE SIGNED 4-4-60									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-5-60		22c. NAME OF CEMETERY OR CREMATORIUM Mt. Zion		22d. LOCATION (City, town, or county) Highland, Md		(State) Md	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md		ADDRESS		24a. REC'D BY REGISTRAR DATE APR 5 '60		24b. REGISTRAR'S SIGNATURE Charles L. Krause			



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FOR STATE
HEALTH DEPT.MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
4642 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO DIRECTOR: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Howard		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission) a. STATE Maryland		b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Box 186 RFD				d. STREET ADDRESS Box 186 RFD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOSHUA ANDREW		First Middle Last		4. DATE OF DEATH DITMAN April 24, 1960		Month Day Year	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Aug. 24, 1905	
9. AGE (In years last birthday) 54 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bio Chemist		11. BIRTHPLACE (State or foreign country) Oxford, Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Josephus Ditman		14. MOTHER'S MAIDEN NAME Mary E. Polster		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Lewis Ditman, College Park, Md		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Address	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO		DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Peter Rieckert, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> Medical Investigator <input checked="" type="checkbox"/>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 4/25/60	
EXAMINER'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 27, 1960		22c. NAME OF CEMETERY OR CREMATORIAL Forest Park Cemetery		22d. LOCATION (City, town, or county) College Park - Carroll	
23. FUNERAL DIRECTOR Arthur S. Kraus		ADDRESS Forest Park Cemetery, Md.		24a. REC'D BY REGISTRAR Arthur S. Kraus		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	
VS. A15ME 5M 7/59		DATE APR 27 '60					

4642

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland		b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural - Ellicott City		c. LENGTH OF STAY IN 1b 9 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural - Ellicott City		d. STREET ADDRESS RFD #2 (Triadelphia Road)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RFD #2 (Triadelphia Road)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Laura		First Effie	Middle Iglehart	4. DATE OF DEATH April	Month 4	Day 19	Year 60		
5. SEX female		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 19, 1871	9. AGE (In years from birth) 88	10. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Isaac Iglehart		14. MOTHER'S MAIDEN NAME Josephine Stansfield							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Ernest Harris, RFD #2, Ellicott City	Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] Part I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocardial failure</u>						INTERVAL BETWEEN ONSET AND DEATH 3 months			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. 420.0		(b) <u>Arteriosclerotic heart disease</u>				20 years			
DUE TO (c)									
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from <u>May 21, 1946</u> , to <u>April 4, 1960</u> , that I last saw the deceased alive on <u>April 3, 1960</u> , and that death occurred at <u>2:00 A.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state)						DATE SIGNED	
ACTUAL SIGNATURE <u>Charles S. Whitaker</u> , M.D.									
PHYSICIAN'S NAME (Type) Charles S. Whitaker, M.D.		Clarksville, Maryland						4-4-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-4-60		22c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet		22d. LOCATION (City, town or county) Clarksville, Maryland		(State)	
23. FUNERAL-DIRECTOR'S SIGNATURE <u>John D. Wright</u>		ADDRESS <u>Clarksville, Md.</u>		24a. REC'D BY REGISTRAR APR 7 '60		24b. REGISTRAR'S SIGNATURE <u>Charles S. Whitaker</u>			
VS A15 (4) 15M 9/55									

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it in pencil, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MM3. Form 5 may be retained by the Funeral Director. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. ATSMES
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4651 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

646/7

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkridge				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenburnie					
c. LENGTH OF STAY IN lb 6100 Race Road Private Res.				d. STREET ADDRESS Hill Crest					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6100 Race Road Private Res.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) ANNIE		First PARRISH	Middle 	Last 	4. DATE OF DEATH April 11 1960	Month April	Day 11	Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH June 20, 1876	9. AGE (In years last birthday) 83 yrs	IF UNDER 1YEAR Months 0			IF UNDER 24 HRS. Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Simpsonville, Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. ? Unknown		17. INFORMANT Wm. Parrish, Glenburnie, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardio Vascular Disease						INTERVAL BETWEEN ONSET AND DEATH 5 yrs.			
422.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Glen Burnie		(County) Baltimore	(State) Md
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>									
ACTUAL SIGNATURE George E. Burgtoft		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED April 11, 1960			
EXAMINER'S NAME (Type) George E. Burgtoft		M.D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 14th Apr. '60		22c. NAME OF CEMETERY OR CREMATORIUM Glen Haven Cemetery		22d. LOCATION (City, town, or county) Glen Burnie, Maryland		(State) Md	
23. FUNERAL DIRECTOR'S SIGNATURE R. V. Singleton		ADDRESS Glen Burnie, Maryland		24a. REC'D BY REGISTRAR Apr 14 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Reed			

450.0

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4645

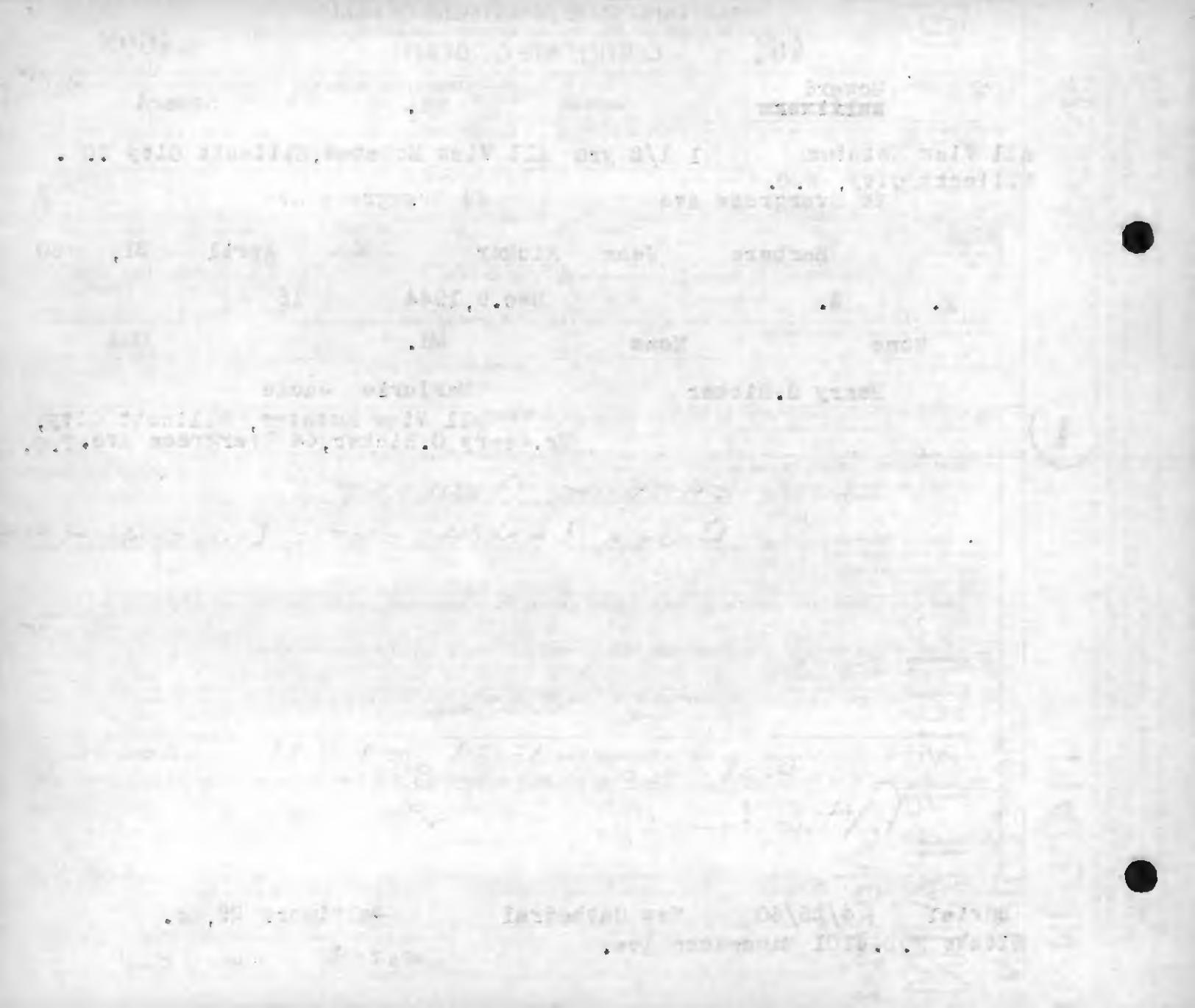
CERTIFICATE OF DEATH

64608

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Howard		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) All View Estates		c. LENGTH OF STAY IN 1b 1 1/2 yrs	
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) All View Estates, Ellicott City RO.		c. LENGTH OF STAY IN 1b 1 1/2 yrs	
e. FIRM, CITY, P.O. (not in P.O. give street address) OR INSTITUTION 44 Evergreen Ave		d. STREET ADDRESS 44 Evergreen Ave	
e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Barbara		First Barbara	Middle Jean
4. DATE OF DEATH April 21, 1960		Lost	Month April Day 21 Year 1960
5. SEX F.		6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Dec. 9, 1944		9. AGE (in years last birthday) 15 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry C. Ricker		14. MOTHER'S MAIDEN NAME Marjorie Jacke	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT All View Estates, Ellicott City, Mr. Henry C. Ricker, 44 Evergreen Ave. P.O.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. DUE TO (b) CARDIAC ARREST DUE TO (c) Have Lymphocytic Leukemia 4 mos	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 12-24 (County) 1960 (State) to 4-21	
21. I certify that (I) (this hospital) attended the deceased from 12-24 1960 to 4-21 , 1960 and that death occurred at 8:50 AM , from the causes and on the date stated above.		22b. DATE SIGNED	
22a. SIGNATURE D. H. Ricker		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/25/60	
23c. NAME OF CEMETERY OR CEMETORY New Cathedral		23d. LOCATION (City, town, or county) Baltimore 29, Md. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Witzke F. D. 4101 Edmondson Ave.		25a. REC'D BY REGISTRAR APR 26 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4640 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

64609

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

1. PLACE OF DEATH a. COUNTY Howard		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkridge 27 Rt. 4		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkridge		d. STREET ADDRESS Rt. 4 Box 266	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rt. 1 and Kit Kat Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) AMANDA SCHULZ		First	Middle	Last	4. DATE OF DEATH Month April	Day 8	Year 1960
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED	b. DATE OF BIRTH July 26, 1877	9. AGE (in years last birthday) 82.	IF UNDER 1 YEAR Months 82.	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? Germany	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME Effey		Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT None Mrs. Hilda German, Elkridge 27, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)		Cerebral Hemorrhage				INTERVAL BETWEEN ONSET AND DEATH 10 MIN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Cardiovascular Disease		5 years					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) None					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Baltimore, Md	(County) Baltimore, Md
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE George E. Burgtorf		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 4-8-60	
EXAMINER'S NAME (Type) George E. Burgtorf M.D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-11-1960		22c. NAME OF CEMETERY OR CREMATORIAL Loudon Park		22d. LOCATION (City, town, or county) Baltimore, Md	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md		ADDRESS		24a. REC'D BY REGISTRAR DATE APR 11 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	
VS. A15ME(5) 5M 9/55							

01 SHOWERS-MAKIN' NO TIME FOR STANDING
MAKIN' NO STANDING-REMINICKS RADIO- 20